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What would my parents think: intergenerational transmission of attitudes toward seeking professional psychological help

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What would my parents think: Intergenerational transmission of attitudes toward seeking professional psychological help

by

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ABSTRACT

This study focused on the intergenerational transmission of attitudes toward help seeking. Parental attitudes, attachment to parents, sex, and community size were examined to determine their influence on college students' attitudes toward help seeking. Data were collected via an on-line survey from 195 parent-child pairs (104 mother-daughter, 30 mother-son, 44 father-daughter, and 17 father-son). Parents' ages ranged between 38 and 76 years old and students' ages ranged from 18 to 38 years. Hierarchal regression analyses revealed that parental attitudes toward help seeking significantly influenced students' attitudes. In addition, attachment to mother, but not father, influenced students' attitudes. Implications for mental health care providers are discussed.

INTRODUCTION

In a time where mental health and mental illness are receiving increasing attention, renowned psychologist Dr. Phil has his own talk show, and self-help books are often on the bestseller list, it seems unusual that many people experiencing mental health and/or relationship problems do not seek professional help. Nearly one in five Americans experiences a mental disorder in the course of a year, and approximately 15% of all adults who have a mental disorder in one year also experience a co-occurring substance use disorder (Leaf, Livingston Bruce, & Tischler, 1986; Surgeon General's Report, 1999). Yet, according to Kessler, Nelson, McKinagle, Edlund, Frank and Leaf (1996), it is estimated that more than half of all Americans experiencing mental illness do not seek treatment.

There are many reasons why people experiencing mental and/or relationship problems may choose to not seek treatment. Research has identified two barriers to help seeking behavior: structural barriers, such as money and access to treatment (Leaf et al., 1986; Surgeon General's Report, 1999), and cognitive barriers (Leaf et al., 1986; Leaf, Livingston Bruce, Tischler, & Holzer, 1987; Surgeon General's Report, 1999; Vogel & Wester, 2003) such as stigma toward the mentally ill and attitudes about counseling. Although the structural barriers play an important role in help seeking behaviors, cognitive barriers and family attitudes have been found to be nearly as strong an influence (Leaf et al., 1986).

Although everyone living in the United States may experience structural and cognitive barriers, people living in rural communities experience additional obstacles that exacerbate the problem. Specifically, rural communities have fewer treatment facilities per capita, causing individuals who are seeking treatment to drive greater distances to the nearest

facility (Bischoff, Hollist, Smith, & Flack, 2004; Des Moines Register, 2005). In addition, rural areas tend to be disproportionately poor, thus creating additional barriers to driving long distances for professional psychological help (Leaf et al., 1987). Also, it has been suggested that rural areas of the United States have different value systems concerning how one deals with problems and to whom one tells their problems (Bischoff et al.). In addition, people living in small communities experience unique issues with anonymity that people in urban areas do not experience. Specifically, in smaller communities, everyone knows what everyone else is doing and tends to discuss other people's activities (i.e., gossip). It has also been found that people living in smaller communities are more concerned with what their family will think if they see a therapist than people living in larger cities, and this has a bearing on whether or not they seek treatment (Bischoff et al; Clark, Leukefeld, & Godlaski, 1999). Because of this added concern related to family approval, I believe that parents, through modeling and reinforcement, influence their adult children's attitudes toward help seeking.

Research on intergenerational transmission of attitudes from parents to their children has produced robust but somewhat mixed results. As in most social science research, the process of intergenerational transmission is complex and thought to be influenced by many factors. Many researchers believe that one possible influence on intergenerational transmission is the gender concordance between the model and the child, or the like-sex hypothesis (Bussey & Bandura, 1984). The like-sex hypothesis postulates that children emulate like-sex models over opposite-sex models because same-sex models are more similar to them (Bussey & Bandura). However, other theorists believe that the attachment quality between caregivers and their children is also a strong influence on modeling because

a child will selectively adopt similar attitudes and behaviors of the parent(s) to which they are securely attached and can trust (Bretherton, Golby, & Cho, 1997). Both influences have been neglected in the literature and the small amount of research that has been conducted has produced mixed results. Therefore, the purpose of this study was to look at the intergenerational transmission of attitudes toward help seeking with these two influences in mind.

Why is this important? I believe this is an important study for three reasons. First, there has been no research focusing on the role parents' attitudes play in their children's help seeking attitudes. This study benefits the mental health field because it provides further understanding of how family-of-origin attitudes influence adult children's help seeking attitudes. Second, some intergenerational transmission research has looked at the like-sex influence on modeling and a few other studies have looked at attachment, but no research has looked at them simultaneously. This study is beneficial to intergenerational transmission research because it evaluates both influences to identify which has the stronger effect. Third, there is very little research looking at rural attitudes toward help-seeking. Given that 21% of Americans live in rural areas, the mental health field, especially outreach programs in rural areas of the United States, may benefit from this study because it specifically looks at a rural population.

In order to examine the intergenerational transmission of attitudes toward help seeking with like-sex and attachment theory in mind, adult children and their parents were recruited for this study. Specifically, all Iowa State University undergraduates were sent an email asking for their participation and their parents' participation in this study. The surveys contained questions regarding their attitudes toward help seeking, their intent to seek

counseling services, their experiences with counseling, and several demographic questions. Using hierarchal regression, the following five hypotheses were investigated.

Hypotheses

Following are five hypotheses that were tested in this study.

1. Mothers' and Fathers' attitudes toward seeking professional psychological help will influence their children's attitudes toward seeking professional psychological help.
2. A mother's attitudes toward help seeking will be more influential than a father's attitudes on their daughter's attitudes, and a father's attitudes toward help seeking will be more influential than a mother's on their son's attitudes (like-sex modeling theory).
3. Secure attachment to a parent will increase parental influence on their child's attitudes toward seeking professional psychological help (attachment theory).
4. Secure attachment to a parent will be a stronger influence than like-sex parent influence on a child's attitudes toward seeking professional psychological help.
5. Attitudes of rural individuals toward seeking professional psychological help and their experiences with mental health services will be more negative than attitudes of urban individuals.

LITERATURE REVIEW

Barriers

There are many potential reasons why individuals experiencing mental health and/or relationship problems do not seek help, and these reasons tend to fall into one of two types: structural barriers and cognitive barriers. Structural barriers include demographic characteristics such as age, sex, income, and education, along with non-demographic barriers, such as accessibility and affordability of services (Leaf et al., 1986; Surgeon General's Report, 1999). Cognitive barriers include stigma, attitudes toward the mentally ill, attitudes toward the efficacy of mental health services (Leaf et al., 1986, 1987), and attitudes regarding the trustworthiness and effectiveness of mental health treatment for certain populations (i.e., specifically rural people) (Bischoff et al., 2004; Clark et al, 1999; Cook, Copans, & Schetky, 1998). Although the two types of barriers can be thought of as separate, they interact to influence the decision to seek professional help.

Structural barriers affect help-seeking behavior in a variety of ways. It has been found that overall, poor, less-educated, and younger individuals are the least likely to seek mental health services (Leaf et al., 1987). Furthermore, individuals with less education and income also report less accessibility of services, a greater concern about their family's reaction to their help seeking, and greater belief in the family doctor and clergy as providers of mental health services (Leaf et al., 1987). The structural and cognitive barriers come together in this example, demonstrating the synergistic effect on certain groups of people. That is, not only do the poor and less educated have less accessibility and resources (i.e., insurance) to pay for services, but they also report more concern over family member's attitudes toward help-seeking.

Although structural barriers have significant effects on help-seeking (e.g., it is difficult to go to therapy if one cannot afford it), cognitive barriers may have nearly as much impact. For instance, Leaf and colleagues (1986) collected data from 3,058 adults between the ages of 18 and 64 and 1,976 people aged 65 and older as part of the first wave of the Yale Epidemiologic Catchment Area (ECA) Project. This study focused on the incidence and prevalence of major psychiatric disorders and the utilization of health and mental health services. Subjects were interviewed using the Diagnostic Interview Schedule (DIS), and additional questions were asked concerning functioning, social support, and attitudes toward mental health facilities. Researchers found that 24% of the sample believed that a family member would become upset if they sought help for a personal or emotional problem, and that receptivity ($\chi^2 = 6.61$, $df = 1$, $P < 0.01$) and anticipation of upsetting family ($\chi^2 = 10.68$, $df = 1$, $P < 0.01$) were significantly related to utilization (Leaf et al., 1986). Furthermore, it was found that among subjects who have had (or still have) a psychiatric disorder, those who demonstrated positive attitudes toward mental health services or who said their families would not get upset if they sought treatment were more likely to use mental health services (Leaf et al., 1986).

Negative attitudes about consumers of mental health services also play a role in help-seeking behavior (Cooper, Corrigan, & Watson, 2003; Corrigan, Swantek, Watson, & Kleinlein, 2003; Leaf et al., 1986; Wahl, 1999). For example, Wahl (1999) found that consumers of mental health services experience negative reactions from the people around them. In this study, 1,301 persons with diagnosed psychiatric disorders were asked about their experience of stigma and discrimination in regard to their mental illness. Of those 1,301 persons, nearly 80% reported witnessing or overhearing negative comments about people

with mental illness, making it the most commonly reported stigmatizing experience. Seventy percent of respondents said they had at times been treated as less competent than others, and 27% reported being told to "lower their expectations in life" and were instructed to accept jobs below their ability level (Wahl, 1999, p. 470). In addition, 32% said they were turned down for jobs (for which they felt they were qualified) after revealing they were a mental health consumer. Of those who were employed, 28% felt their supervisors and co-workers were "seldom or never supportive and accommodating when they learned about the respondent's mental illness" (Wahl, 1999, p. 471).

A follow-up interview was also conducted with 100 of the respondents in Wahl's (1999) study to gather more in-depth information. What is especially troubling is the number of respondents who reported negative treatment by family members and caregivers. Relatives were the second most commonly reported source of stigma. Personal interviews revealed condescending treatment, being watched carefully, and rejection as common stigmatizing behaviors displayed by family members (Wahl). Surprisingly, professionals in the mental health field were also guilty of stigmatizing and discriminating behavior. A common complaint among those interviewed was that they were often discouraged from setting high goals by mental health workers in charge of their care. After being diagnosed with a mental illness, one respondent was told by her doctor, "people with your problem will have a very low level type of life" (Wahl, 1999, p. 473).

Stigma and discrimination have tragic and lasting effects. Not surprisingly, stigmatizing treatment was reported to decrease self-esteem and confidence, and cause many individuals to avoid telling others about their mental illness (Wahl, 1999). While not disclosing information about their mental illness relieved some of the pressure, it also

produced anxiety in many patients because they then worried their secret would be found out. Over half of the respondents reported that they worry often or very often about their mental illness being discovered. One-third of respondents reported that because of negative, stigmatizing experiences, they avoid social contact, and one-fifth said that they are less likely to apply for jobs or educational opportunities (Wahl).

Stigma and the corresponding negative treatment of the mentally ill may in part be due to the attitudes people hold about who is to blame for mental illness (Cooper et al., 2003). Cooper et al. examined the complicated relationship between stigma and care-seeking. Seventy-nine participants from a community college were asked about their care-seeking behavior and their attitudes toward mental illness. Several assessment instruments were used, including the Attribution Questionnaire and the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) questionnaire, to find out about the help-seeking attitudes of these students. The data revealed some interesting findings. Previous help-seeking behavior was significantly related to willingness to seek psychological help. In contrast, respondents were less likely to seek mental health services if they viewed people with mental disorders as responsible for the disorder, did not pity them, and reacted to them with anger. The authors suggested this finding corresponds with the attribution model as it relates to blame. That is, those who blame individuals for their mental illness (i.e., see them as responsible for it) are less likely to seek services themselves, do not deem themselves deserving of help, and believe they should overcome the mental illness on their own (Cooper et al.).

Gender also influences help-seeking behavior in complicated ways. Some research has concluded that men and women experience mental illness at about the same rate, yet women disproportionately seek treatment more often than men (Leaf et al., 1986). Other

research has concluded that women experience certain psychiatric disorders and mood disorders more often than men and that this is due to a combination of biological and environmental factors (Blumenthal, 1994).

In the Yale Epidemiologic Catchment Area Project study, the researchers found that although rates of disorders did not differ by gender, women were 1.5 times more likely than men to seek treatment (Leaf et al., 1986). Furthermore, researchers found that some of the gender differences in help-seeking behavior can be explained by a differential effect of attitudes (Leaf et al., 1986). Specifically, among subjects meeting criteria for a mental illness diagnosis, positive attitudes toward mental health services had a significant effect on help-seeking only for female respondents (Leaf et al., 1986). Also, among those same females, perceived increase in access barriers had a negative effect on treatment seeking, suggesting women are differentially affected by both attitudes and perceived barriers than men. However, in the same study they found that this effect only holds for women who are diagnosed with a disorder and need treatment; among individuals not needing mental health services, women are no more likely to report that they would use services than men (Leaf et al., 1986).

Furthermore, in another Leaf et al. study (1987) differential effects were again found between men and women. Using the same Yale Epidemiologic Catchment Area Project data, this study looked at the relationship between demographic factors and attitudes toward mental health services. It was found that overall women were more receptive to mental health treatment and were less worried about their family's reaction than men. This finding supports the earlier finding that men and women are differentially affected by the potential stigma and attitudes regarding seeking professional psychological help.

The differential gender effects are complicated and difficult to explain. Leaf et al. (1986) believe that attitudes, family concerns, and perceived barriers may hinder or facilitate help-seeking more strongly during the initial stages of a problem as compared to later stages. They hypothesize that because women seek treatment at the beginning stages of a problem and men tend to delay seeking treatment until later stages, the differential gender effects may in part be due to the stage of problem at which men and women seek help. Although this is an interesting gender finding, it exceeds the scope of the present study and will not be examined further in this thesis.

In conclusion, barriers to seeking professional mental health services are varied and differentially affect various groups of people. While structural barriers, such as cost and access to services, could potentially limit help-seeking, they have been shown to have a greater affect on young, poor, and less-educated populations (Leaf et al., 1987). In addition, cognitive barriers such as concern about what family members will think, attitudes toward those who seek professional help, and stigma have been shown to weigh heavily on the decision to seek professional help and may affect men and women differently (Cooper et al., 2003; Leaf et al., 1986; Leaf et al., 1987; Wahl, 1999). For the purposes of this study, it is important to be cognizant of how obstacles affect each group differently. This study investigated cognitive barriers such as attitudes toward seeking professional psychological help and intent to seek counseling with a specific population, rural individuals, in mind.

Rural

Mental health treatment in rural communities, as compared to urban areas, presents many unique issues for both mental health professionals and clients (Bischoff et al., 2004; Catalano, 1997; Clark et al., 1999; Des Moines Register, 2005). According to U. S. Census

data (2000), 21% of people in the United States live in rural communities, yet this population is often ignored and under-researched (Spoth, 1997; Surgeon General's Report, 1999). In addition, the number of mental health facilities, clinics, and professionals is much lower in rural areas and not sufficient to meet the needs of mental health consumers (Bischoff et al.; Des Moines Register; Surgeon General's Report). This combination of lack of research on treatment in rural communities and lack of treatment resources presents problems for both therapists and clients in rural areas.

As discussed previously, there are both structural and cognitive reasons why people experiencing mental health and/or relationship problems would not seek professional help. Due to a combination of factors, people living in rural areas experience structural and cognitive barriers more strongly than people living in urban areas (Bischoff et al., 2004; Surgeon General's Report, 1999). Research has demonstrated that the poor and less educated are the least likely to seek mental health services (Leaf et al., 1987). Sadly, rural Americans are disproportionately poor, less educated, and underemployed (O'Hare & Johnson, 2004). In addition, as a result of the farm crisis of the 1980s, many rural communities have experienced an extended period of economic and emotional hardship (Ortega, Johnson, Beeson, & Craft, 1994; Hoyt, O'Donnell, & Mack, 1995). Rural America has historically had higher poverty rates than urban America, however, that gap seems to be widening. In a report by O'Hare and Johnson, using Census data and data obtained through the Anne E. Casey Foundation, the authors compared child poverty rates in urban and rural areas in 1994 to rates in 2002 and found that there has been a four percent increase in the gap in just eight years. In fact, according to the 2000 Census data, 48 of the 50 counties reporting the highest child poverty rates were rural (O'Hare & Johnson).

Another disturbing phenomenon happening to rural communities is the flight to urban areas due to a decrease in family farming and a lack of economic opportunities. Children growing up in farm communities are leaving after high school in order to find more lucrative career opportunities in larger cities (O'Hare & Johnson, 2004). Due to the high rates of poverty and the shrinking population in rural areas, rural America is losing political pull (Danbom, 1995; O'Hare & Johnson). As a consequence, rural mental health concerns are not a priority for mental health policy makers (Ahr & Holcomb, 1985). With rural economies in decline and the population decreasing in most rural areas, rural America is in need of accessible and affordable mental health care.

High poverty rates and low numbers of mental health facilities create extreme accessibility problems for rural Americans (O'Hare & Johnson, 2004; Surgeon General's Report, 1999). People with little resources to pay for care are understandably unlikely to utilize mental health services, especially if utilizing those services requires driving long distances (Bischoff et al., 2004; Des Moines Register, 2005). In a recent Des Moines Register (2005) article regarding the shortage of psychiatrists in Iowa, the author reported that, according to state records, 66% of Iowa counties do not have private practice psychiatrists. Furthermore, according to the U. S. Department of Health and Human Services, Iowa is ranked 47th among states in psychiatrists per resident (Des Moines Register). Another Midwestern rural state, Nebraska, is no better off. Sixty-seven of 93 counties in Nebraska are considered mental health professional shortage areas, meaning that the services in those counties are insufficient to meet the needs for care, and 22 (or 24%) counties in Nebraska have no mental health services at all (Nebraska Health and Human Services, 2002). Because of this shortage, rural people seeking mental health treatment must travel long distances and

take time off from work. This results in lost wages and travel expenses, which many people in rural areas cannot afford (Bischoff et al.; Catalano, 1997; Des Moines Register).

In addition to lost wages, protecting confidentiality for rural residents is problematic. In a case study conducted by Bischoff et al. (2004), respondents reported that when they took time off from work they often felt compelled to tell co-workers the reason why they were leaving. Furthermore, many people felt they also had to tell family members about seeking treatment because they would rather tell them than have them find out from someone else (Bischoff et al.). This is a concern for people in rural communities because they are more likely to rely on family, possibly more so than people in urban areas, and to care what family members think of them (Clark et al., 1999). The lack of confidentiality experienced by people in rural areas is a common and somewhat unavoidable problem in small communities due to the lack of anonymity given the low population density (Bischoff et al.).

What is especially problematic about the concern that other people will know if rural Americans seek therapy is the stigma attached to seeking professional help (Bischoff et al., 2004; Clark et al., 1999; Cook et al., 1998; Surgeon General's Report, 1999). While stigma is experienced across the United States, it is believed that the stigma is worse in rural communities due to a culture that is skeptical of therapy and believes people should solve their own problems (Bischoff et al.; Cook et al.; Surgeon General's Report, 1999). In the Cook et al. article, the authors identify the following characteristics as commonly found in rural communities: strong family ties, lack of discussion of feelings, avoidance of conflict, assertion of independence, substantive religious involvement, limited tolerance of diversity and deviance, fatalistic and stoic attitudes, and fear, misunderstanding, and stigmatization of mental illness. The authors conclude that this combination of characteristics significantly

hinders help-seeking behavior (Cook et al.). In the Bischoff et al. study, residents of a rural community universally expressed the opinion that small communities are less open to therapy than urban areas as a means to solve their problems. Participants speculated that this is because rural areas are behind the times and generally prefer to solve problems on their own (Bischoff et al.). The combination of greater skepticism of mental health services and greater concern with what family members think in rural communities creates a major barrier to utilizing mental health services (Bischoff et al.; Clark et al.; Cook et al.).

Because rural America is skeptical of mental health treatment, it is important for therapists to tailor treatment to the culture of small communities. Unfortunately, this rarely happens and can be a major obstacle for both therapists and clients. This problem stems from the fact that most treatment programs are developed and studied in urban populations. Little to no research exists to determine whether these programs are as effective for rural populations (Clark et al., 1999; Surgeon General's Report, 1999). The lack of research makes it difficult to generalize the findings from major studies of treatment programs in urban settings to rural populations (Clark et al.). In two recent articles, the authors speculated that these treatment programs are a poor fit for rural communities and that they fail to take into consideration culturally embedded values and norms that may affect treatment, such as a greater reliance on the family, limited resources, and greater suspicion of mental health treatment (Clark et al.; Cook et al., 1998). The authors were concerned with this lack of research and felt that it was greatly affecting the quality of treatment in rural communities, thereby increasing the suspicion toward mental health treatment (a self-fulfilling prophecy) (Clark et al.; Cook et al.).

Because of low population density, another unique concern for therapists and a possible barrier to treatment for people in small towns is the challenge of managing dual relationships (Catalano, 1997; Cook et al., 1998). A dual relationship occurs when the therapist takes on more than one role in his or her client's life, such as a neighbor or a fellow school board member. Therapists in small communities will likely know their clients on multiple levels, making it impossible to avoid dual relationships. The combination of low population density and multiple relationships between people in small communities can potentially increase the intensity of relationships, making dual relationships even more emotionally confusing for therapists and clients (Catalano). Unfortunately, the issue of dual relationships in small towns is often under-addressed in training programs and the counseling field in general. The lack of concern in the counseling field and lack of knowledge regarding practicing in a small community could lead to poorly trained mental health professionals and contribute to rural people's skepticism and decision to not seek counseling.

In conclusion, people living in rural areas compared to people living in urban areas face additional challenges when deciding whether or not to seek professional psychological help (Bischoff et al., 2004; Catalano, 1997; Clark et al., 1999; Cook et al., 1998; Des Moines Register, 2005; O'Hare & Johnson, 2004; Spoth, 1997; Surgeon General's Report, 1999). It has been found that poor and less-educated individuals are the least likely to seek mental health services (Leaf et al., 1987). According to the report by O'Hare and Johnson, rural areas are increasingly poorer and the people in these communities typically have lower levels of education. In addition, due to the shortage of mental health professionals in rural areas, individuals must travel long distances, take time off from work, and wait long periods of time before receiving psychological help (Bischoff et al.; Cook et al.; Des Moines Register;

Surgeon General's Report). Furthermore, due to the stigma and skepticism toward the mental health field found within the culture of rural America, seeking professional psychological help may incur too high an emotional risk for most individuals to take (Bischoff et al.; Cook et al.). The lack of mental health professionals, coupled with the lack of training focusing on the rural culture, is a potentially dangerous problem that deserves more attention. In the present study, a focus was placed on a rural population and participants were asked about their attitudes toward seeking professional psychological help, in addition to the quality and appropriateness of the care they have received.

Intergenerational Transmission

Research has demonstrated the influence of intergenerational transmission of many types of values, beliefs, and behaviors, such as self-acceptance, affiliation, and financial success values (Kasser, Ryan, Zax, & Sameroff, 1995); prejudice (Sinclair, Dunn, & Lowery, 2005); fear of failure (Elliot & Thrash, 2004); work values (Kulik, 2004); and divorce (Amato & DeBoer, 2001; Feng, Giarrusso, Bengtson, & Frye, 1999; Kulik). Intergenerational transmission of beliefs and values is believed to take place through a combination of modeling and reinforcement, which are the basic tenants of social learning theory (Bandura & McDonald, 1963). Attachment is also believed to play a role in intergenerational transmission, in that children adopt the values and behaviors of their parents to whom they are securely attached (Bretherton et al., 1997). Children adopt similar values to their parents, not because they fear punishment but because they love and feel close to them.

Social Learning Theory

Social learning theory contends that children from a young age have the difficult task of figuring out how to think, act, and behave. In order to simplify the process and make sense of the world, children model the behaviors of people around them (Bandura, 2003). Through their own unique process, children choose models that they look up to. Early in life, these models are typically their parents. Parents communicate their values through words and behaviors to their children, and when children emulate those values, they are rewarded and reinforced (Bandura; Sinclair et al., 2005). Simultaneously, when children say or do things that go against parental values, they are typically punished. Therefore, social learning of values, beliefs, and behaviors is a combination of modeling, direct instruction, and reinforcement.

It is impossible for parents to model specific values, opinions, or ideas for their children. Therefore, social modeling is thought to occur at a high level of cognitive functioning whereby parents pass a general set of values to their children that can be applied to a variety of situations (Bandura, 2003). While every judgment or opinion may not have been modeled, a set of values was communicated and this set can be applied to a variety of phenomena. For example, an individual may have never heard his or her parents express an opinion regarding seeking professional counseling, but still have an idea what his or her parents think about counseling based on a broad set of values (e.g., one that values privacy and solving one's own problems with little or no help from outside the immediate family).

Modeling activities by parents enable children to generate new behaviors and attitudes (Bandura, 2003). In observational learning, children act out the principals or standards modeled in the behaviors exhibited by others they choose to emulate. According to

Bandura, much human learning occurs from the models in one's immediate environment. However, ideas, values, belief systems, and lifestyles are also constructed from the extensive modeling in the symbolic environment. There are many sources of potential models for children such as parents, peers, media, and literature. People are exposed to a multitude of modeling influences and there is wide variation in the ideas, values, and lifestyles being modeled. Hence, social modeling is not a matter of incorporation of one given model, but rather a social construction in which elements from one's array of experiences are combined (Bandura).

Considering the theory of social construction of modeling, one might assume it is difficult or even impossible to determine specific influences on values and behavior. However, research on intergenerational transmission has found strong support for the influence of parents on their children's values and beliefs (Amato & DeBoer, 2001; Elliot & Thrash, 2004; Feng et al., 1999; Kasser et al., 1995; Kulik, 2004; Sinclair et al., 2005). For example, in the Kulik study, 15-year old adolescents (n = 100) and their parents (n = 200) were asked questions about their attitudes regarding family life. Specifically, the researcher looked at attitudes toward homosexuality, gender roles, and divorce, and compared parental attitudes to contemporary media messages to determine which was more influential. Significant concordance was found between parents and their children on attitudes regarding family life. For example, attitudes toward homosexuality were highly correlated between parents and their children, ranging from $r = .41, p = < .01$ to $r = .61, p = < .001$ (Kulik). Because significant correlations between one or both parents and their adolescent children was a robust finding, Kulik concluded that, while we live in a changing world where each

generation is brought up in a new environment, parents are still highly influential in the formation of values and beliefs.

There have been some mixed results concerning the intergenerational transmission of values and beliefs. For example, in the Kulik (2004) study mentioned previously, significant correlations were found between the attitudes of children and their parents overall. However, some specific differences in attitudes were found between children and parents in the areas of divorce and gender roles. That is, Kulik found that parents and children shared the same attitudes regarding gender roles (father-son $r = .51$, $p = < .001$; mother-son $r = .50$, $p = < .001$; mother-daughter $r = .37$, $p = < .01$) but had dissimilar attitudes on divorce (mother-son $r = .17$, *ns*; father-daughter $r = .10$, *ns*; mother-daughter $r = .24$, *ns*). There were two exceptions to these findings. First, fathers and daughters did not share the same attitudes about gender roles ($r = .17$, *ns*), and fathers and sons shared the same views of divorce ($r = .27$, $p = < .05$). Therefore, although significant correlations were found between parents and children on attitudes toward homosexuality, the data on gender roles and divorce produced mixed results. The author suggests that intergenerational transmission is a complicated phenomenon that varies by culture, individual, and attitude, and that mixed results are a reasonable outcome for such a complicated issue (Kulik). In the literature on intergenerational transmission there are many possible explanations for the mixed results. However, the like-sex and attachment hypotheses appear to dominate the literature.

Those who argue for the like-sex intergenerational transmission explanation, or the passing of values from a parent to the same gender child (i.e., mothers to daughters and fathers to sons, Bussey & Bandura, 1984) contend that children imitate same-sex models more readily than opposite-sex models because same-sex models are more similar to them. In

their study, Bussey and Bandura had young children watch a group of male and female models perform different tasks, and then observed which models the children emulated. Overall, children imitated the same-sex model over the opposite sex model, which led the researchers to conclude that the like-sex hypothesis is robust.

Similarly, according to Bem's (1981) gender schema theory gender plays an important role in identity formation and affects how people evaluate appropriate behavior. Gender is an identity-organizing construct that shapes the way people view themselves and others. Therefore, it is believed to be an important factor in modeling behavior. Furthermore, according to cognitive-developmental theory, children imitate like-sex models because it is the simplest way to organize their environment and choose which models to emulate (Bussey & Bandura, 1984). Gender is one of the first categories children can understand. In the confusing world of a child, it is easier to emulate people who seem more similar. Because of the importance of gender in shaping an individual's experiences, many believe that there is more attitude agreement between like-sex dyads than between opposite-sex dyads in families, and that this could clarify the mixed results found in intergenerational transmission research (Kulik, 2004).

Although the like-sex hypothesis makes sense, there is research that does not support it. For example, in the Kulik (2004) study, the like-sex hypothesis was only partially supported. While like-sex intergenerational transmission was strong between fathers and sons, there was no effect for mothers and daughters in that mothers' attitudes were equally correlated with both sons and daughters attitudes. In addition, overall girls' attitudes were equally highly correlated with both of their parent's attitudes (as compared to being more highly correlated with mothers' attitudes), further refuting the like-sex hypothesis (Kulik).

The author attributed the differences in boys and girls to the different socialization process each goes through and felt that fathers showed a tendency to treat sons and daughters differently. By contrast, mothers tend to treat them more similarly (Kulik). Regardless of the explanation, there appears to be something else occurring that is affecting the like-sex transmission of values.

Although Bussey and Bandura (1984) found robust like-sex results, in a second experiment they found that social power mediated those results. The researchers instructed some models to control rewarding resources (i.e., social power) in order to see if the children would still emulate the like-sex model (Bussey & Bandura). The findings from this research are interesting because they neither refute the like-sex hypothesis nor do they necessarily support it. Instead, Bussey and Bandura found that boys modeled opposite-sex models when they exhibited social power, whereas girls continued to model the same-sex regardless of social power. Furthermore, they found that girls tended to emulate both models but favored like-sex models, whereas boys strongly emulated like-sex models until social power was introduced.

The authors offered two explanations for their results. The first was that boys in our society are taught to embrace masculinity and reject femininity, which explains why the like-sex phenomenon is so robust with boys. However, when you introduce social power, which is a traditionally masculine quality in western society, boys will emulate opposite-sex models because they are behaving in a way boys associate with being masculine. In essence, the boys could identify with this behavior. Conversely, girls are not taught to reject masculinity. Therefore, they will emulate same-sex models because it is familiar and similar to them, but they will also emulate opposite-sex model behavior because they have not been taught to

reject it (Bussey & Bandura, 1984). Similar outcomes occurred in the Kulik (2004) study. Specifically, girls were more likely to hold attitudes highly correlated with both parents, whereas boys' attitudes that were more highly correlated with their fathers than with their mothers' attitudes.

Attachment Theory

One competing theory to the like-sex hypothesis is attachment theory. This theory contends that people adopt their parents' values and beliefs to the degree that they are securely attached to them. Using an attachment theory perspective suggests that children internalize their parents' expectations and values to the extent that their parents have consistently met their emotional and physical needs (i.e. are securely attached) (Bretherton et al., 1997; Grusec & Goodnow, 1994; Kasser et al., 1995; Sinclair et al., 2004). Although social learning theory explains the general framework of intergenerational transmission, attachment theory explains how and why certain beliefs and values are transmitted across generations. It is believed that children's values are a function of the expressed beliefs of their parents and the degree to which children are securely attached and identify with their parents. More securely attached children should absorb their parents' beliefs and values more so than children who have an insecure attachment to their parents.

Attachment theory, originally developed by John Bowlby and Mary Ainsworth, has gained much attention over the past decade and has been one of the most popular theories used to explain the nature of both child and adult relationships (Simpson & Rholes, 1998). The basic premise of attachment theory is that the first relationship one has with his or her parent(s) serves as the blueprint for all subsequent relationships. This blueprint has lasting affects, both positive and negative and has the potential to greatly influence many aspects of

an individual's life, such as parent-child interactions, value development, relationships with peers, relationships with romantic partners, and one's mental health (Thompson, 1999). Attachment is thought to be strongly influenced by responsiveness and availability of the caregiver. The major constructs associated with attachment theory (i.e., attachment bond, attachment behavioral system, exploratory behavioral system, caregiving behavioral system, internal working model, and secure family base) combine to determine the quality of the attachment between parents and children (Cassidy, 1999).

The attachment bond refers to a specific type of bond one experiences with an individual whom they perceive as stronger and wiser, and from whom they are seeking security and comfort (Cassidy, 1999). It is similar to an affectional bond in that it does not fade or go away easily, the person with whom the individual feels the bond is not interchangeable, the relationship is emotionally significant, the individual wants to stay physically close to the person, and the individual feels upset when involuntarily separated from the person (Cassidy). Thus, this is why the parent-child relationship is so important to children and can have lasting effects throughout their life.

The characteristics of the attachment bond are typically seen with parent-child relationships, but can also be seen with relationships that are perceived as having the same characteristics, such as a sibling, grandparent, or other designated caregiver. The bond typically refers to protecting qualities of the relationship, but can also refer to playing, feeding, and teaching behaviors (Cassidy, 1999). In addition to the characteristics of the bond, the quality of the bond is also important. The quality is determined by a combination of the amount of interaction between the caregiver and the child, the quality of care provided (including the ability of the caregiver to meet the child's emotional and physical needs) and

the amount of investment the caregiver has in the child (Cassidy). These factors all play a part in how the child experiences the attachment and determine the degree to which the child can trust that the parent is looking out for their best interest.

The attachment behavioral system refers to a set of behaviors employed by a child in order to meet his or her goal of gaining access (usually to reduce stress brought on by an internal or external stressor) to his or her attachment figure (Cassidy, 1999). In other words, when infants are distressed and cannot find their mothers, they may try different behaviors so the mother will return. For example, they may try looking for her by crawling and, if that does not work, they may cry, and if that does not work, they may cry even harder and louder. There are a variety of behaviors that can be employed, and they are flexible in order to adapt to the needs of the situation. Seeking protection and comfort in an attachment figure is thought to be an inherent motivation, as evidenced by a child's preference to seek proximity with even an abusive parent.

The exploratory behavioral system, closely linked to the attachment behavioral system, refers to children's comfort level with exploration in light of their caregiver's presence or absence (Cassidy, 1999). If a child has developed a strong and reliable set of attachment behaviors, then the child is more likely to have a healthy and active exploratory behavioral system. In other words, if the child has been able to trust that he or she will not be abandoned and that he or she can trust the caregiver to respond when needed, then the child is more likely to be willing to venture out on his or her own without fear of being left to fend for himself or herself if he or she encounters trouble. The ability to explore one's environment is necessary for development; therefore, both the attachment behavioral system

and the exploratory behavioral system are vital for healthy functioning in children in order for them to learn about their environment.

Just as children have a system of attachment behaviors with which to draw from, so do caregivers. The caregiver behavioral system, as the name indicates, is a set of behaviors caregivers might choose from in order to protect their children and enhance the attachment bond (Cassidy, 1999). One of the most important caregiver behaviors is retrieval, which refers to the parent retrieving the child in some way when the child is in danger or distressed (Cassidy). In addition, the caregiver behavior system is not limited to protection, but can also refer to attachment enhancing behaviors such as play, feeding, and teaching.

The child and caregiver attachment behavior systems interact in dynamic ways and are constantly responding to each other. When the caregiver attachment system is activated, the child system tends to be deactivated and vice versa (Cassidy, 1999). It is this constant balance of give and take that determines the quality of the attachment bond. When the delicate balance is disrupted, the attachment bond can be affected. For example, if the caregiver must work outside the home in order to provide for the child, the child may not have the proximity to the parent he or she desires. If the distance is too great, the child may feel that he or she cannot depend on the protection of the parent. The child may choose to try one of his or her attachment behaviors in order to increase proximity, which may not produce the proximity he or she craves. In the case of a child separated from a parent, the child may act out at school or daycare, causing the parent to have to pick them up. This behavior would thus increase proximity for at least a short period of time. However, this strategy would likely be met with negative outcomes because it would lead to stress and anger in the parent.

The internal working model is a "blueprint" formed by the first relationships one has with his or her caregiver(s) that is then used as a model for future relationships. It is a representational relationship formed by thoughts of one's caregiver, self, and the environment (Cassidy, 1999). Because it is a representational model, the internal working model is used to shape and organize the attachment behaviors of children and adults. When deciding which attachment behaviors to use, a child will utilize his or her internal working model to help guide his or her decisions.

It is important to note that this can be problematic if the internal working model is not a realistic depiction of reality, as in the case of inconsistent caregiving or abuse (Cassidy, 1999). For example, an abused child's internal working model would represent relationships to others as dangerous and frightening. Thus, an abused child may avoid close relationships with others in order to protect him or herself. Because not all relationships with others will be abusive, this is not an accurate depiction of reality and will likely harm the child's social development and ability to function successfully in society. The child will likely decide that his or her parents are not looking out for his or her welfare so they cannot be trusted. Children who are insecurely attached to their parents and can no longer trust that parent will likely look for other models of behavior.

The attachment bond has traditionally been identified using the Strange Situation Test developed by Mary Ainsworth. During the experiment, children are separated from their caregivers and then reunited. The most telling part of the test is the reunion; this is where researchers look to determine the quality of the attachment. Based on how children react when reunited with their caregivers, the researchers categorize children into four categories

of attachment: secure, avoidant, resistant or ambivalent, and disorganized/disoriented (Simpson & Rholes, 1998).

As discussed previously, consistent care and the ability of a caregiver to meet the emotional and physical needs of the child tends to lead to secure attachment. When reunited with their caregivers in the Strange Situation Test, secure children are quickly soothed and calmed by the presence of their caregiver. A consistent *lack* of care by the caregiver tends to produce an avoidant attachment where the child gives up attempting attachment behaviors because those behaviors have not worked in the past (Ainsworth, Blehar, Waters, & Wall, 1978). Inconsistent or intermittent care by a caregiver tends to produce a clingy and overly distressed attachment behavior system in children because they have learned that they must show more extreme behaviors before they will receive the attention they seek. When reunited with their caregiver, ambivalent children are not easily soothed and remain upset for an extended period of time. Disorganized and disoriented attachments tend to be found in children whose parents were sexually, emotionally, and/or physically abusive. These children display strange, unorganized behaviors when separated from and reunited with their caregivers (Ainsworth et al.). These behaviors may seem unusual, however, they are actually normal considering the child is trying to adapt to an unpredictable and terrifying environment.

Attachment styles, like most social behaviors, are passed from parents to children through a complicated process of internalizing caregiver relationships and modeling (Simpson & Rholes, 1998). Parenting styles that are warm, responsive, and available tend to produce children who are secure. Styles that are inconsistent tend to produce children who are ambivalent. Styles that are unavailable and unresponsive tend to produce children that are

avoidant. Styles that are abusive tend to produce children who are disorganized/disoriented in their attachment style (Simpson & Rholes). Thus, although a child will bond with a parent regardless of how the parent responds to the child's needs, the quality and style of the attachment is highly influenced by parental responsiveness.

Attachment issues have the potential to affect people beyond childhood and into adulthood, as evidenced by the breadth of research on the topic. In the area of attachment, two main research foci emerge: attachment in the nuclear family and attachment in the peer/romantic partner relationship (Simpson & Rholes, 1998). Research on the nuclear family focuses on attachment between parent and child relationships (Simpson & Rholes; Ainsworth et al., 1978), whereas the research on the peer/romantic partner relationship looks at the influence of attachment on relationships between friends and romantic partners (Hazan & Shaver, 1987, 1994; Collins & Read, 1990). These two areas of research demonstrate the influence of attachment throughout life (Simpson & Rholes). Although attachment studies have examined the influence of attachment on parent-child relationships (Simpson & Rholes; Ainsworth et al.), adult relationships (Hazan & Shaver, 1987, 1994; Collins & Read), and mental health (Bowlby, 1973; Mikulincer, Florian, & Weller, 1993), few studies have examined how attachment influences value transmission between parents and children.

One study that has attempted to examine the relationship between attachment and value transmission was a study by Sinclair et al. (2005). They looked at the effect of parents' racial prejudice on children's racial prejudice. The sample was drawn from two schools in the Midwest and consisted of 25 girls and 33 boys (78 children were White, 2 were Hispanic, 1 was Asian American, and 8 did not report their ethnicity) and 89 primary caretakers (the study did not report the caretaker's ethnicity). The authors speculated that prejudice develops

in part through the role of parents during their offspring's childhood. In addition, they suggested that the intergenerational transmission of prejudice was moderated by the degree to which children "identified" with their parents. In the article, "identification" was defined by the degree to which children were securely attached to their primary caregiver (Sinclair et al.). The degree to which children identified with their parents was assessed using a four-item questionnaire, and the level of prejudice was assessed using a six-item questionnaire. The authors then examined the interactive effect of identification on the concordance of prejudice between 89 child/parent pairs.

The results of the study supported the hypothesis. Specifically, children who are highly identified (e.g., securely attached) to their parents hold racial attitudes that are more similar to those of their parents when compared to children who are less identified (e.g., insecurely attached) with their parents, $F(3,56) = 3.89$, $p < .02$ (Sinclair et al., 2005). In addition, the predicted interaction between identification and value transmission was found ($\beta = .30$; $p = .02$). When parental identification was one standard deviation above the mean, a positive relationship was found between parental prejudice and children's prejudice ($\beta = .45$, $p < .01$). However, when parental identification was one standard deviation below the mean, the parent's and children's prejudice scores were unrelated ($\beta = -.08$, $p = .63$). The authors concluded that children and parents hold similar levels of prejudice to the degree that children identify with their parent.

Attachment theory is one of the most prominent theories in the study of parent-child and peer/romantic relationships. Although it has been used as the theoretical framework for a multitude of studies, it has been neglected in the study of value transmission evidenced by a lack of research on the topic. Intergenerational transmission of behaviors and values from

parents to children is a complicated process with many possible influences. Because attachment has been determined to be a vital factor in human development, it was decided that it would be beneficial to study the influence of attachment on the value transmission of attitudes toward seeking professional psychological help.

METHOD

Participants

Participants were 195 parent-student pairs (104 mother-daughter, 30 mother-son, 44 father-daughter, and 17 father-son). The parent-student pairs used in the analyses consisted of 134 mothers, 61 fathers, 148 daughters and 47 sons. Of the student participants, 16% were freshman, 26% were sophomores, 25% were juniors, and 33% were seniors. The age range for the students was 18 to 38 years old (M = 28), and for parents it was 38 to 76 years old (M = 57).

Ethnic characteristics of the sample were 94% White (n = 184), 2% Asian or Pacific Islander (n = 5), 1% Black or African American (n = 2), 1% Hispanic (n = 2), and 1% other (n = 2), which is similar to the ethnic characteristics of the university undergraduate population. Religious preferences of the sample included Protestant (44% of the parents and 30% of the students), Catholic (29% of the parents and 22% of the students), LDS (2% of the parents and 2% of the students), other (14% of the parents and 20% of the students), and none (10% of the parents and 24% of the students). Parents' reported annual income included: 11% stated they earned $0-$20,000, 19% earned $20,001-$40,000, 31% earned $40,001-$70,000, 16% earned $70,001-$100,000, 19% earned $100,001 or more, and 4% chose not to answer. The mean income was $40,000-$70,000.

Seventy-seven percent of the student participants grew up in an intact family with two biological parents (n = 151), 14% experienced divorce or lived in a single parent family (n = 28), 6% lived in a stepfamily with one biological parent and one stepparent (n = 12), and 6% reported they grew up in none of those family structures (n = 11). Students also reported on the current marital status of their parents: 67% were married (n = 132), 14% were divorced (n

= 28), 12% were remarried (n = 24), 3% were widowed (n = 6), 2% were single/never married (n = 3), and 2% were unknown (n = 3).

For the purposes of this study, cities and towns with populations of 50,000 or less were considered "rural" whereas cities with populations greater than 50,000 were considered "urban" (Surgeon General's Report, 1999). Sixty percent (n = 118) of the parents reported living in a rural community and 40% (n = 78) reported living in an urban community. Sixty-nine percent (n = 131) of the students reported growing up in a rural community and 33% (n = 65) reported growing up in an urban community.

Parents and students were asked if they had ever sought counseling. Forty percent (n = 77; 54 females, 23 males, 3 missing data) of the parents reportedly sought counseling. Of those parents who sought counseling, 43% (n = 33) currently live in urban communities and 38% (n = 44) live in rural communities. Thirty-nine percent (n = 75; 60 females, 15 males, 1 missing data) of the students previously sought counseling. Of those students who previously sought counseling, 46% (n = 30) were raised in urban communities and 35% (n = 45) were raised in rural communities.

Students and parents also reported on their experiences of seeking counseling. Of those rural parents who previously sought counseling, 35% reported they had a "very good" experience, 47% had a "good" experience, 13% had a "poor" experience, and 5% had a "very poor" experience. The urban parents who previously sought counseling reported that 36% had a "very good" experience, 46% reported a "good" experience, 15% reported a "poor" experience, and 3% reported a "very poor" experience. The rural students who previously sought counseling reported that 24% had a "very good" experience, 45% reported a "good" experience, 23% reported a "poor" experience, and 8% reported a "very poor" experience.

Finally, of those urban students who previously sought counseling, 25% reported they had a "very good" experience, 43% reported a "good" experience, 24% reported a "poor" experience, and 8% reported a "very poor" experience.

Procedure

IRB approval was obtained in order to collect data from a sample of Iowa State University students (see Appendix A). Next, a list of current e-mail addresses for all undergraduate students (N = 20,732) was purchased from the Iowa State University Registrar's Office. There were 1,232 undergraduate students (805 females, 415 males, 11 missing data) who completed the survey, and 237 parents (170 females, 67 males) who completed it. This represented a 6% response rate for students.

Two e-mails, requesting participation in the on-line survey, were sent to the undergraduate students (see Appendix B). The second e-mail was sent two weeks after the first email. An informed consent statement was included in the e-mails sent to students (see Appendix B). Subjects gave their consent by clicking the "continue" button prior to responding to the on-line survey questions. On the last page of the survey, a screen appeared that thanked the students for their participation and then asked them to have their parents participate in the parent survey. A copy of the last page of the survey is included in Appendix B. Students were provided with three methods to include their parents in the survey. First, they could forward a link to their parents which directed them to a website containing the parent survey. Second, students could pick up a paper copy of the survey to give to their parents. Third, a paper version of the survey could be sent to their parents' address. One student picked up a packet and 12 surveys were mailed to parents. Of the surveys mailed, seven were returned. All versions of the parent survey included an informed consent

statement to be acknowledged (clicking the continue button for the on-line survey, signing the consent form for the paper version) prior to completion of the survey.

All participants were asked to enter the student's Iowa State e-mail address when completing the survey. This e-mail address was used to match parents with students for purposes of data analyses and to identify gift certificate winners. After all surveys were completed, student and parent participants were entered into a drawing for a chance to win a $40.00 gift certificate from Target. One student participant and one parent participant were randomly chosen to receive gift certificates. One gift certificate was sent through the postal service and the other was collected in person.

Prior to analysis with SPSS 13.0 software, data were cleaned. Some data were deleted for the following reasons. A total of 38 student cases were deleted because they were duplicates. Parent and student cases were deleted when surveys were only partially completed (4 parents and 18 students) and when e-mail addresses were missing (14 parents and 180 students). In addition, when both mothers and fathers completed the survey, father's data were included in analyses because there were fewer father-student cases. This eliminated 22 mother cases.

Measures

Both parent and student participants were asked to complete the Attitudes Towards Seeking Professional Psychological Help, Short Form (ATSPPH-short; Fischer & Farina, 1995). This scale is comprised of 10 items and is a shortened version of the original 29-item questionnaire (see Appendix C). Participants rated their attitudes on seeking psychological help using a four-point Likert scale ranging from 1 (disagree) to 4 (agree). Items were summed, with high scores indicating favorable attitudes regarding seeking psychological

help. Fischer and Farina (1995) reported a coefficient alpha of .84 for the 10-item measure for a sample of 389 college students (modal age = 18 years, 55% were female). The coefficient alpha of the current sample for parents was .83 and for students was .85. In the Fischer and Farina study, the mean score was 17.5 (*SD* = 5.97). In the current sample, the mean score for parents was 29.22 (*SD* = 5.41) and for students was 27.05 (*SD* = 5.80).

Student participants completed a shortened version of the Intention of Seeking Counseling Inventory (ISCI) (see Appendix C). The original scale was a 17-item questionnaire created by Cash, Begley, McCown, and Weise (1975). The shortened version, created by Cepeda-Benito and Short (1998), identified three subscales using factor analysis. The Psychological and Interpersonal Concerns subscale was used in the current study. Respondents rated how likely they were to seek counseling if they were experiencing certain problems using a Likert scale ranging from 1 (very unlikely) to 6 (very likely). Responses on the ISCI were summed across the 10 items, with higher scores indicating a greater likelihood of seeking counseling. In the study by Cepeda-Benito and Short the coefficient alpha of the subscale was .90 with a sample of 732 undergraduate college students (mean age 19.50 years, 65% women). For the current study, the shortened ISCI measure was used for young adults (see Appendix C). The coefficient alpha of the current sample was .87 for students. In the Cepeda-Benito and Short study, the mean for the ISCI was not reported. For the current measure, the mean score for students was 21.55 (*SD* = 5.52).

Student participants completed the Adult Attachment Scale (AAS) in order to measure the strength of the attachment to their mothers and fathers (Cicirelli, 1995) (see Appendix C). The strength of the attachment between adult children and their mother and father was measured by asking respondents to rate the degree to which they agree with the

statements regarding feelings toward their mother and father on a scale ranging from 1 (strongly agree) to 7 (strongly disagree). The questions are based on the original research on attachment and represent the following areas: seeking security or comfort, distress upon separation, joy upon reunion, and feelings of love or closeness. Responses are summed and possible scores range from 16 to 112 for the total score, with higher scores indicating stronger attachment to the parent. A coefficient alpha of .95 was found in the Cicirelli (1995) study of 138 adult daughters (aged 38-62). The coefficient alpha of the current sample was .96 for student reports of attachment to mothers and .97 for reports of attachment to fathers. In the Cicirelli study, the mean score was 82.88 (SD = 20.08) for daughters' attachment to mothers. For the current measure, the mean score for attachment to mothers was 77.30 (SD = 22.12) and the mean score for attachment to fathers was 69.01 (SD = 25.30).

Both parent and student participants also completed demographic questions (age, sex, size of community in which participant grew up, education, and parents' marital status) and questions assessing whether participants had sought professional psychological help, quality of services, and other influences (e.g., an outside source) on attitudes toward help-seeking (see appendix C).

RESULTS

Initial descriptive statistical analyses were conducted to determine if there were any problematic data. In addition, t-tests and a chi-square test were run to determine if there were differences between the 195 student participants (the participants who were matched with their parents) and the 1,232 student participants whose parents did not complete a survey. Specifically, t-tests were run on the ATSPPS, ISCI, and AAS. In addition, a chi-square test was conducted on the percentage of students who stated they had previously sought counseling. None of the t-tests or the chi-square test were significant, therefore, it was determined that the two groups were not different in their attitudes, intent, attachment levels, or history of help seeking. Also, a t-test was run to determine if there was a difference between the 195 student participants and the normative data reported for the ATSPPS. A significant difference was found between the 195 student participants ($M = 27.05$, $SD = 5.80$) and the normative data ($M = 17.5$, $SD = 5.97$), $t(194) = 22.55$, $p = .00$. Specifically, it was found that the students in the current study held considerably more favorable attitudes toward help-seeking than the students in the Fisher and Farina (1995) study.

All scores on the measures were standardized before analyses were conducted in order to lessen the correlation between the main effects of the predictor variables and the interaction terms that are created by multiplying together the predictor variables. A series of hierarchal regression analyses were conducted to determine influences on students' attitudes toward help seeking. In addition, regression analyses were conducted to test if people from urban communities had more favorable attitudes toward help seeking than people from rural communities. All tables are presented in Appendix D of the thesis.

Results for Specific Hypotheses

Hypothesis 1

Hypothesis 1: Mothers' and fathers' attitudes toward seeking professional psychological help will influence their children's attitudes toward seeking professional psychological help. To examine this hypothesis, community size and sex of parent and student were controlled in step one of the regression analysis, $R^2 = .07$, $F(4, 189) = 3.54$, $p = .01$ (see Table 1). In step two, the standardized score for parents' attitudes toward help-seeking was entered into the regression analysis, $\Delta R^2 = .048$, $F(1, 188) = 10.19$, $p = .00$. Parents' attitudes ($\beta = .23$, $p = .00$) and students' sex ($\beta = -.24$, $p = .00$) were significant in explaining students' attitudes toward seeking help. These results provide evidence for the influence of parents' attitudes on children's attitudes toward help-seeking, and demonstrate that in the current sample, female students have a more favorable attitude toward help seeking than male students.

Hypothesis 2

Hypothesis 2: Mother's attitudes toward help seeking will be more influential than a father's attitudes on their daughter's attitudes, and a father's attitudes toward help seeking will be more influential than a mother's on their son's attitudes (like-sex modeling theory). To examine hypothesis 2, interaction terms were included in the regression analysis. Thus, in step three a two-way interaction of sex of student by parents' attitude, a two-way interaction of sex of parent by parent attitude, and a two-way interaction of sex of student by sex of parent were entered. Step three was not significant, $\Delta R^2 = .01$, $F(1, 188) = .92$, $p = .43$ (see Table 1). Finally, in step four a three-way interaction of sex of child by sex of parent by parents' attitude was entered. Step four was not significant, $\Delta R^2 = .00$, $F(1, 184) = .06$, $p =$

.81 (see Table 1). Therefore, hypothesis 2 was not supported because none of the predicted interactions used to test the like-sex hypothesis were significant (sex of student by parent attitude $\beta = .12$, $p = .21$, sex of parent by parent attitude $\beta = -.02$, $p = .87$, sex of student by sex of parent $\beta = .00$, $p = .10$, and sex of child by sex of parent by parent attitude $\beta = .03$, $p = .81$).

Hypothesis 3

Hypothesis 3: Secure attachment to a parent will increase parental influence on their child's attitudes toward seeking professional psychological help (attachment theory). To examine this hypothesis, community size and sex were again controlled in step 1 of the regression analysis. Parents' attitude and attachment to parents were entered in step two (see Table 2). Finally, a two-way interaction of parents' attitude by attachment to parents was entered in step three (see Table 2). The interaction was not significant, $\Delta R^2 = .00$, $F(1, 181) = 010$, $p = .75$, and therefore, hypothesis 3 was not supported.

After conducting the regression analysis it was discovered that attachment to mother was highly correlated with attachment to father ($r = .40$) and collinearity was believed to be affecting the results. In order to address this, the two attachment scores were combined into one score, thereby creating a composite parental attachment variable. In addition, parent and student community size were found to be highly correlated ($r = .67$), therefore, only the parent community size was entered into the regression. The same analyses were conducted again, only this time the composite variable was used (see Table 3). Once again, the model with the interaction in step three was not significant, $\Delta R^2 = .00$, $F(1, 187) = .01$, $p = .91$; however, attachment was found to be moderately significant in predicting students' attitudes, $\beta = .14$ $p = .06$.

In order to investigate this further, the same analyses were conducted separately for mothers and fathers. In these analyses it was discovered that attachment to fathers (see Table 4) was not significant, $\beta = .08$ $p = .28$, whereas attachment to mothers (see Table 5) was significant, $\beta = .18$ $p = .02$, in predicting students' attitudes toward seeking help. However, the interactions of attitude by attachment were not significant; thus, hypothesis 3 was not supported.

Hypothesis 4

Hypothesis 4: Secure attachment to a parent will be a stronger influence than like-sex parent influence on a child's attitudes toward seeking professional psychological help. Hypothesis 4 was not tested because the like-sex hypothesis (Hypothesis 2) was not supported, and attachment was not found to increase the influence of parents' attitudes on children's attitudes (Hypothesis 3).

Hypothesis 5

Hypothesis 5: Attitudes of rural students toward seeking professional psychological help will be more negative than attitudes of urban students. As previously mentioned, it was determined that parent and student community size were highly correlated ($r = .67$) and therefore collinear, so the regression analyses were conducted using only student variables. To examine this hypothesis, students' and parents' sex and students' community size were controlled in step one (see Table 6). In step two, a two-way interaction of student sex by student community size was entered into the model in order to determine if there was any associated sex by size of community interactions (see Table 6). Step two of the regression was not significant. Therefore, hypothesis 5 was not supported, student community size and the predicted interaction used to test sex differences were not significant (see Table 6). Thus,

it was concluded that in this sample community size did not influence students' attitudes toward help-seeking. However, it was found that there was a trend for females and community size ($\beta = -.64$, $p = .09$).

Another regression analysis was conducted to determine if community size had an effect on students' intent to seek counseling (versus attitudes toward help-seeking). The same regression model, correcting for collinearity, was used with intent to seek counseling as the dependent variable. Students' sex and community size were controlled in step one, $R^2 = .05$, $F(3, 190) = 2.98$, $p = .03$. Once again, the regression analysis was not significant in step two, $\Delta R^2 = .02$, $F(1, 189) = 3.17$, $p = .09$ (see Table 7). Therefore, community size did not influence students' intent to seek counseling.

Additional Analyses

In this sample, the vast majority of the parent-child pairs involved data from one parent only. However, in 22 cases both parents completed the survey. Additional analyses were conducted on the 22 cases to determine if there was any differential attitude or attachment effects by parent sex. In step one, student sex was controlled, in step two mothers' attitude and fathers' attitude were entered, in step three attachment to mother and attachment to father were entered, and in step four, two-way interactions of mothers' attitude by attachment to mother and fathers' attitude by attachment to father were entered. Although attachment to mother was again significant (see Table 8), none of the other variables were significant.

DISCUSSION

It has been estimated that more than half of all Americans experiencing mental illness do not seek treatment (Kessler et al., 1996). Research on the reasons for this phenomenon has focused on structural and cognitive factors that influence help seeking behavior. In particular, research on the intergenerational transmission of values and attitudes passed down from parents to children has produced robust but somewhat mixed results. Therefore, the purpose of this study was to evaluate several factors thought to influence the transmission of help-seeking attitudes within families. One unique aspect of this study was the examination of several factors simultaneously. That is, both the sex of the parent (like-sex hypothesis) and attachment to parent (attachment hypothesis) were examined in this study. Furthermore, we attempted to examine the influence that living in rural America has on help-seeking attitudes and willingness because this sample was predominately (69%) rural.

The findings of this study support the overall idea that parents' attitudes toward help seeking influence their children's attitudes. This finding, in addition to sex, was the most robust result of the study. This finding seems to be in agreement with the principals of social learning theory which proposes that children have the difficult task of determining how to think, act, and behave, and in order to simplify the process and make sense of the world, children model the behaviors of people around them (Bandura, 2003). Children tend to choose models that they look up to, and early in life these models are typically their parents. This appears to also be the case with the current sample. However, it is important to note that this finding only accounted for a small proportion of the variance ($r^2 = .07$) indicating that there is much to learn about factors that influence attitudes toward help seeking.

The findings of this study appear to replicate the findings of a previous study that examined the influence of intergenerational transmission of attitudes regarding family life (Kulik, 2004). In the Kulik study, significant agreement was found between parents and their children on attitudes regarding family life. Because a significant correlation between one or both parents and their adolescent children was a robust finding, Kulik concluded that, while we live in a changing world where each generation is brought up in a new environment, parents are still influential in the formation of values and beliefs. The current study adds to this body of literature because it extends the areas of parental influence. That is, Kulik found parental influence in the areas of gender roles and sexuality, whereas the current study found that parents also influence attitudes toward help-seeking.

Post hoc analyses revealed that attachment to one's mother also influences children's attitudes; however, it was not necessarily in the way that was proposed in this study. Specifically, attachment to mothers was predictive of children's attitudes, but it did not increase the influence of that parent's attitude on their child's attitude. Instead, it seemed to demonstrate that children who are more securely attached to their mothers tend to have more positive attitudes toward help-seeking. Interestingly, this finding has been replicated in a recent study by Vogel (2006). In the study it was determined that attachment contributed to the anticipated benefits and risks of seeking counseling, which then influenced help seeking attitudes and intentions.

What is it about a secure attachment to mothers that positively influences children's attitudes toward help seeking? Perhaps "openness to counseling" is an effect of secure attachment. Specifically, those children who were raised with warm, responsive, and available parents produce adults who feel comfortable seeking professional psychological

help. As the attachment literature argues, attachment styles, like most social behaviors, are passed from parents to children through a complicated process of internalizing caregiver relationships and modeling; and parenting styles that are warm and responsive tend to produce secure children (Simpson & Rholes, 1998). Is there something about secure children that leads to an acceptance of counseling? This is an interesting finding and one that deserves further attention.

Conversely, all of the predicted interactions of parental attitudes and attachment to parents were not found to be significant. Although parents' attitudes are predictive of students' attitudes toward help-seeking, the sex of the parent and attachment to that parent do not seem to affect the influence the parent has on his/her child's attitudes. However, as discussed previously, perhaps attachment works in a different way. Specifically, it may be the case that a child who did not form a secure attachment to a parental figure may hold less favorable attitudes toward help seeking. According to the attachment literature, trust is an important factor in the development of the parent-child relationship (Cassidy, 1999). Perhaps if the parenting style is inconsistent and non-responsive, the child may grow up not trusting others. This may be an important factor in help seeking due to the amount of trust that is necessary to engage in the therapeutic process. Further research is clearly warranted in this area.

In addition, the match between sex of parent and child (the like-sex hypothesis) did not appear to strengthen the influence of parental attitudes toward help-seeking. This finding is contrary to the findings of the Bussey and Bandura (1984) study, which demonstrated that small children were more likely to imitate like-sex models. Although there are many differences between the Bussey and Bandura study and this study, an important difference

may be that the subjects in this study were adults and they were asked about their attitudes, whereas the subjects in the Bussey and Bandura study were small children and they were evaluated on their behaviors. Perhaps a small child is more likely to imitate those who they feel are similar to themselves in obvious ways, whereas adults have a further developed cognitive ability to choose who to emulate based on more complex processes.

Finally, sex of student was consistently found to be associated with positive attitudes toward help-seeking. That is, females consistently held more positive attitudes than males. This seems to be a robust finding in much of the literature on help-seeking and this study was able to replicate those findings (Blumenthal, 1994; Leaf et al., 1986; Leaf et al., 1987). It appears that women consistently hold more positive attitudes toward help-seeking than men. However, it is important to note that the current study only provided evidence that females tended to have more positive attitudes than males, but did not investigate why this is so. It has been demonstrated in the literature that sex influences help seeking behavior in complicated ways. Some research has concluded that men and women experience mental illness at about the same rate, yet for a variety of reasons women seek treatment more often than men (Leaf et al., 1986). Other research has concluded that women experience certain psychiatric and mood disorder more often than men and that this is due to a combination of biological and environmental factors (Blumenthal, 1994). Further research investigating sex differences in attitudes toward help-seeking would be beneficial in shedding more light on why women appear to hold more favorable attitudes.

The prediction that rural students would hold less favorable attitudes toward help-seeking than urban students was not supported. Also, the majority of students and parents who had previously sought therapy reportedly had a "good" or "very good" experience and

this did not differ by community size. Although much of the research has suggested that people living in rural communities, for a variety of reasons, would be more skeptical of therapy, leery of seeking professional help, and have more negative experiences, the results did not find that to be true in this study. Perhaps attitudes are changing and people from urban and rural communities are becoming more homogenous in their attitudes toward mental health treatment. Also, it could be that rural Iowans and urban Iowans hold similar attitudes toward help-seeking. Iowa may be too homogenous of a state to compare people based on community size. Perhaps attitudes toward help seeking vary by region and not within state; for example, a more accurate "rural versus urban" comparison might be between a Costal state and a Midwestern state.

Limitations

Due to the fact that much of the data were unusable when students and parents were paired together, it is difficult to draw broad conclusions based on this sample. This sample was collected by sending surveys via e-mail to all ISU undergraduate students and then asking them to send a survey to their parents. There may have been something special about the students who were willing to complete a survey about help-seeking and who were willing to send a survey to their parents. For example, the majority of the parents (67%) in the final data set were still married, which may not be representative of the general population. One could argue that a student would have to be close to his or her parents to be willing to send them a survey about help seeking. Therefore, perhaps the parent-child pairs used in the sample were closer and had stronger attachment relationships than the general population. Furthermore, it was found that the students in the current study held significantly more positive attitudes to help seeking than the students in the Fisher and Farina (1995) study. This

is just another indication that the sample was unique so findings may not be generalizable to the larger student population.

Another limitation was the low response rate. Only 6.2% of the students responded, which could likely represent a special subset of the population. That is, one that likes to answer questions about help seeking. Furthermore, this sample was predominately White (94%), and although it is representative of the university student population and the population of the state, it is not representative of the population across America. Due to the lack of diversity in this sample, there may be differences between Whites and other ethnic groups that were not detected in the current study. Finally, it is important to note that this study examined attitudes and intent, but not behaviors. One's reported attitude does not always coincide with one's behavior. Therefore, results from this study do not reveal whether parent attitudes toward help seeking influence their adult child's help seeking behavior.

These are important factors to keep in mind when considering the results of this study. However, it is important to note that in this relatively small sample, it was found that parents' attitudes did indeed influence their children's attitudes. In addition, it was found that a more highly secure attachment to one's mother tends to positively affect one's attitudes toward help-seeking, which was an interesting and unexpected finding. Future longitudinal research is needed with a larger, more representative sample size to attempt to replicate these findings. A larger sample size would hopefully encompass a more diverse population and one that is more representative of true "urban" and "rural" communities (perhaps regional instead of within state) and of the diverse family structures found in the general population. In addition, a longitudinal study would be better able to measure behaviors in addition to attitudes and intent.

Implications

The influence of parents' attitudes on their adult children's attitudes has valuable implications for the mental health community. It is important for therapists to be aware of the importance of parental acceptance of counseling when working with individuals and families. Therapists may unintentionally underestimate the influence parental attitudes have on their children's attitudes, especially if their "children" are adults. In the present sample, the "children" were all adults of varying ages and parental attitudes did seem to have an influence. Based on this information, it would be beneficial for therapists to educate parents on the helpfulness of treatment so that they will encourage their children to seek it out if needed.

CONCLUSION

There is still much to be learned about the factors that influence people's attitudes toward seeking professional psychological help. This study has shed some light on the intergenerational transmission of attitudes from parents to their children, and has demonstrated that parents' attitudes do influence the attitudes of their children to some degree and that attachment may play a role in the process. I am hopeful that these results will benefit therapists by providing evidence of the importance of parental support to individuals and families seeking help.

APPENDIX A. IRB LETTER

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office of Research Assurances
Vice Provost for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

February 22, 2006

Natalie Lonsdale
4018 Lawnwoods Dr.
Des Moines, IA 50310

Dear Ms. Lonsdale,

Approval Date: February 21, 2006 Date for Continuing Review: February 20, 2007

The Institutional Review Board Co-Chair of Iowa State University reviewed and approved the protocol entitled: What would my parents think: Intergenerational transmission of attitudes toward seeking professional psychological help, on February 21, 2006. The protocol has been assigned the following ID Number: **06-024**. Please refer to this number in all correspondence regarding the protocol.

Your study has been approved for a period of one year from February 21, 2006 to February 20, 2007. The continuation review for this study is no later than February 20, 2007. As a courtesy to you, you will receive a reminder of the approaching review date approximately one month prior this date. A continuing review form must be submitted with sufficient time prior to this date for the IRB to review and approve continuation of the study. Failure to complete and submit the continuing review form will result in expiration of IRB approval on the continuing review date and the file will be administratively closed. A new application for IRB approval will be required to reactivate the study. In addition, all research related activities involving the participants must stop on the continuing review date, until approval can be re-established, except when necessary to eliminate immediate hazard to research participants.

Any changes in the protocol or consent form may not be implemented without prior IRB review and approval, using the "Continuing Review and/or Modification." Research investigators are expected to comply with the principles of the Belmont Report, and state and federal regulations regarding the involvement of humans in research. These documents are located on the Office of Research Assurances website or available by calling (515) 294-4566, www.compliance.iastate.edu.

You must promptly report any of the following to the IRB: (1) **all serious and/or unexpected adverse experiences** involving risks to subjects or others; and (2) **any other unanticipated problems involving risks** to subjects or others.

Upon completion of the project, a Project Closure Form should be submitted to the Human Subjects Research Office to officially close the project.

Sincerely,

Dianne Anderson
IRB Co-Chair

C: HDFS
Marcia Michaels

Office of Research Assurances 12/05

APPENDIX B. SURVEY CORRESPONDENCE

First Email to Students

Subject Line: Attitudes toward seeking professional psychological help

Dear ISU Student,

As a student in marriage and family therapy, I am interested in knowing how to reach people in our community in need of professional psychological help, and what influences the decision to seek or not seek professional services. It would be helpful to gain more information about what affects attitudes toward help-seeking and the decision to seek help in order to better reach those who are currently not seeking treatment, but would like to. That is what I hope to learn through a survey sent out to ISU undergraduate students.

Naturally, your participation is completely voluntary, and you are under no obligation to complete the survey. I do hope you will help. All participants will be entered into a drawing for the chance to win a $40 gift certificate to Target.

This is a study being conducted by a graduate student, Natalie Lonsdale, at Iowa State University under the direction of Marcia Michaels, faculty in HDFS at ISU. It will take approximately 10 – 15 minutes to complete, and of course your answers will be kept strictly confidential.

If you would like to have a written informed consent document sent to you, please contact me at Lonsdale@iastate.edu or 515.296.0730.

You can submit your responses by going to the following website and complete the on-line survey:

http://www.classweb.hs.iastate.edu/Surveys/LonsdaleS

Thanks in advance for your help.

Second Email to Students

Dear ISU Student,

An email was sent several days ago requesting your participation in an on-line study. Your participation in this study contributes to the advancement of knowledge about attitudes toward seeking professional psychological help.

If you have already participated in the study, thank you for your participation! If you have not, please go to http://www.classweb.hs.iastate.edu/Surveys/LonsdaleS
and complete the survey.

Naturally, your participation is completely voluntary, and you are under no obligation to complete the survey. I do hope you will help. All participants will be entered into a drawing for the chance to win a $40 gift certificate to Target.

This is a study being conducted by a graduate student, Natalie Lonsdale, at Iowa State University under the direction of Marcia Michaels, faculty in HDFS at ISU. It will take approximately 10 – 15 minutes to complete, and of course your answers will be kept strictly confidential.

If you would like to have a written informed consent document sent to you, please contact me at Lonsdale@iastate.edu or 515.296.0730.

Thank You,
Natalie Lonsdale

Final Page of Survey

Thank you email to students:

Thank you for participating in the attitudes toward help seeking study! As a second part of the study, I would like to invite either one or both of your parents to also participate. Their information will be kept strictly confidential and there will be no way they can be identified by name.

Naturally, their participation is completely voluntary, and they are under no obligation to complete the survey. I do hope they will help. All parent participants will be entered into a drawing to win a $40 gift certificate to Target. The winner will be identified by his or her child's ISU email address.

You can send the survey to your parents using one of three ways:
1. Simply forward this email to one or both of your parents and ask them to click on the link http://www.classweb.hs.iastate.edu/Surveys/LonsdaleP and complete the survey.

2. You can pick up a survey packet at 84 Lebaron on Wednesdays from 10:00 AM – 12:00 PM and take it to your parents to complete. If you would like to pick up a packet but cannot do it during that time, please call (296-0730) or email me to identify another time.
3. You can email me your parents' name and address and I can send them a survey packet. My email address is: Lonsdale@iastate.edu.

Thank you again for your participation!
Natalie

Informed Consent Document: Hardcopy.

Title of Study: What would my parents think: Intergenerational transmission of attitudes toward seeking professional psychological help
Investigators: Natalie Lonsdale, Marcia L. Michaels, David Vogel, & Dan Russell

The purpose of this research study is to explore the current attitudes toward seeking professional psychological help and to learn about factors that influence those attitudes. You are being invited to participate in this study because you are the parent of a college student at ISU.

If you agree to participate in this study, your participation will last for approximately 10 – 15 minutes. During the study you will be asked to complete a short survey about your thoughts and attitudes toward seeking professional psychological help. You may skip any question that you do not wish to answer. Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

If you choose to participate, you will be entered into a drawing to win a gift certificate of $40 from Target. You will be entered into the drawing using your child's email address and we will inform your child if you have won. Even if you decide to drop out of the study prior to completion, you will be entered into the drawing. The winner will be notified approximately two weeks after completion of the study.

To ensure confidentiality, a code number will replace your name on the questionnaire. All information will be kept in a locked filing cabinet in a locked office at ISU that is only accessible to the research team. When the study is over, the results may be presented to other professionals and published in a professional journal, but identifying information will never be revealed.

It is hoped that the information gained in this study will benefit society by providing clinicians, educators, and researchers with valuable information about what factors influence help-seeking attitudes and behaviors so that outreach programs and alternative treatments can be designed to reach persons who are in need of services, but do not seek them.

You are encouraged to ask questions at any time during this study. For further information about the study contact Natalie Lonsdale at (515) 296-0730, Lonsdale@iastate.edu or Marcia Michaels at (515) 294-8439, marciam@iastate.edu. If you have any questions about the rights of research subjects or research-related injury, please contact Ginny Austin Eason, IRB Administrator, (515) 294-4566, austingr@iastate.edu, or Diane Ament, Director, Office of Research Assurances (515) 294-3115, dament@iastate.edu.

****

SUBJECT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the signed and dated written informed consent prior to your participation in the study.

Subject's Name (printed) _____

_____ _____

(Subject's Signature) (Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the study and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this study and has voluntarily agreed to participate.

_____ _____

(Signature of Person Obtaining Informed Consent) (Date)

APPENDIX C. SURVEY INSTRUMENTS

The Attitudes Towards Seeking Professional Psychological Help – Short Form (ATTSPPH – Short) by Fischer and Farina (1995), Parent and Student Questionnaire

To what extent do you agree or disagree with the statements below:

	Disagree	Partly Disagree	Partly Agree	Agree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	1	2	3	4
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	1	2	3	4
3. If I were experiencing a serious emotional crisis at this point in my life. I would be confident that I could find relief in psychotherapy.	1	2	3	4
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.	1	2	3	4
5. I would want to get psychological help if I were worried or upset for a long period of time.	1	2	3	4
6. I might want to have psychological counseling in the future.	1	2	3	4
7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.	1	2	3	4
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	1	2	3	4
9. A person should work out his or her own problems; getting psychological counseling would be a last resort.	1	2	3	4
10. Personal and emotional troubles, like many things, tend to work out by themselves.	1	2	3	4

Straight items (1,3,5,6, & 7) are scored 3-2-1-0 and reverse scored items (2, 4,8,9, & 10) are 0-1-2-3.

The Adult Attachment Scale (AAS) by Cicirelli (1995): Student Questionnaire, answering for Mother

To what extent do you agree or disagree with the statements below:

Strongly Agree Strongly Disagree
1 2 3 4 5 6 7

1. Being with my mother makes me feel very happy.

2. At times when I have some trouble or difficulty, my mother's image seems to come to mind.

3. If I am unable to see my mother for a long time, it bothers me a lot.

4. When I have not seen my mother for a while, I feel happy when I see her again.

5. When I feel alone and feel anxious, my mother is the first person I think of.

6. When I am with my mother, I feel very close to her.

7. I feel a sense of joy to be with my mother again when we have been separated for a while.

8. I feel lonely when I don't see my mother often.

9. When I am with my mother, I feel that I am with someone I can depend on.

10. If I am in trouble, the first person I want to talk to is my mother.

11. The thought of losing my mother is deeply disturbing to me.

12. When I have been away from my mother for a long time, I feel a sense of security to be with her again.

13. If I feel depressed, my mother is always a source of strength for me.

14. When I am with my mother, I feel that I am with someone I can trust completely.

15. After we have been apart for a time, I feel a sense of relief when I see my mother again.

16. It would be very difficult for me to move far away from my mother.

Responses are summed to yield scores ranging from 16-112.

The Adult Attachment Scale (AAS) by Cicirelli (1995): Student Questionnaire, answering for Father

To what extent do you agree or disagree with the statements below:

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

1. Being with my father makes me feel very happy.

2. At times when I have some trouble or difficulty, my father's image seems to come to mind.

3. If I am unable to see my father for a long time, it bothers me a lot.

4. When I have not seen my father for a while, I feel happy when I see him again.

5. When I feel alone and feel anxious, my father is the first person I think of.

6. When I am with my father, I feel very close to him .

7. I feel a sense of joy to be with my father again when we have been separated for a while.

8. I feel lonely when I don't see my father often.

9. When I am with my father, I feel that I am with someone I can depend on.

10. If I am in trouble, the first person I want to talk to is my father.

11. The thought of losing my father is deeply disturbing to me.

12. When I have been away from my father for a long time, I feel a sense of security to be with him again.

13. If I feel depressed, my father is always a source of strength for me.

14. When I am with my father, I feel that I am with someone I can trust completely.

15. After we have been apart for a time, I feel a sense of relief when I see my father again.

16. It would be very difficult for me to move far away from my father.

Responses are summed to yield scores ranging from 16-112.

The Intent to Seek Counseling Scale-shortened by Cepeda-Benito and Short (1998) – Counseling Outcome Expectancy: Student Questionnaire

Below is a list of issues people commonly bring to counseling. How likely would you be to seek counseling if you were experiencing these problems?

		Very unlikely	Unlikely	Likely	Very likely
1.	Relationship differences	1	2	3	4
2.	Concerns about sexuality	1	2	3	4
3.	Depression	1	2	3	4
4.	Conflict with parents	1	2	3	4
5.	Difficulties dating	1	2	3	4
6.	Difficulty in sleeping	1	2	3	4
7.	Inferiority feelings	1	2	3	4
8.	Difficulty with friends	1	2	3	4
9.	Self-understanding	1	2	3	4
10.	Loneliness	1	2	3	4

Responses are summed to yield scores ranging from 10-40.

Parent Single-item questions: Please answer the following questions. If the exact answer is not listed, please choose the best response.

1. Gender:
    1. Male
    2. Female

2. Ethnicity:
    1. Caucasian
    2. Black or African American
    3. American Indian
    4. Asian or Pacific Islander
    5. Latino
    6. Alaskan Native
    7. Hispanic
    8. Other (specify) _____

3. Amount of schooling completed:
    1. High School or GED
    2. AA Degree, 2 year degree
    3. Bachelors Degree
    4. Master's Degree
    5. PhD, EdD, MD
    6. Other (specify)_____

4. Age: _____

5. Income:
    1. 0-15,000
    2. 15,001-20,000
    3. 20,001-30,000
    4. 30,001-40,000
    5. 40,001-50,000
    6. 50,001-70,000
    7. 70,001-90,000
    8. 90,001-100,000
    9. 100,001 or more

6. Religious Preference:
    1. Catholic
    2. Protestant
    3. LDS
    4. Jewish
    5. None
    6. Other (specify) _____

7. Approximately how large is the town or city you reside in now?
    1. 2,000 or less
    2. 2,001 to 5,000
    3. 5,001 to 10,000
    4. 10,001 to 15,000
    5. 15,001 to 25,000
    6. 25,001 to 50,000
    7. 50,001 to 100,000
    8. 100,001 or greater

8. In your opinion, the community you reside in is predominately:
    1. Urban
    2. Rural

9. What city and state do you reside in? _____

10. Have you previously sought professional psychological help from a counselor?
    1. No
    2. Yes

11. If you answered, "yes" to question #10, in your opinion, in which type of community did you receive treatment?
    1. Urban
    2. Rural

12. If you have previously sought professional psychological help, how would you rate your most recent experience?
    1. Very Poor
    2. Poor
    3. Good
    4. Very Good

13. If you have previously sought professional psychological help, do you feel that your therapist understood you and/or your problem?
    1. Not at all
    2. Somewhat
    3. Yes, very well

Comments:

_____

Student Single-item questions: Please answer the following questions. If the exact answer is not listed, please choose the best response.

1. Gender:
    1. Male
    2. Female

2. Ethnicity:
    1. Caucasian
    2. Black or African American
    3. American Indian
    4. Asian or Pacific Islander
    5. Latino
    6. Alaskan Native
    7. Hispanic
    8. Other (specify) _____

3. Year in college:
    1. Freshman
    2. Sophomore
    3. Junior
    4. Senior

4. Age: _____

5. Religious Preference:
    1. Catholic
    2. Protestant
    3. LDS
    4. Jewish
    5. None
    6. Other (specify) _____

6. How large was the town or city you grew up in? If you moved as a child, the place you spent the majority of your childhood or you believe to be your "home town" or "home city."
    1. 2,000 or less
    2. 2,001 to 5,000
    3. 5,001 to 10,000
    4. 10,001 to 15,000
    5. 15,001 to 25,000
    6. 25,001 to 50,000
    7. 50,001 to 100,000
    8. 100,001 or greater

7. In your opinion, the community you grew up in was predominately:
    1. Urban
    2. Rural

8. What city and state did you grow up in? _____

9. My biological parents are currently:
    1. Married to each other
    2. Divorced
    3. Remarried (one or both biological parents)
    4. Widowed

5. Single, never married
6. Unknown

10. I grew up in an:
    1. Intact family – 2 biological parents
    2. Divorced, single parent family
    3. Stepfamily – 1 biological parent, 1 stepparent
    4. Other

11. 1. I believe my attitudes toward seeking professional psychological help have been greatly influenced by an outside source other than my parents.
    1. Not at all
    2. A little bit
    3. Quite a lot

12. If you do not think your parents had a big influence, who has been the biggest influence on your attitudes toward seeking professional psychological help?
    1. Family member other than mother or father
    2. Friend or boyfriend/girlfriend
    3. Personal experience
    4. Media in general or specific person in the media (includes literature such as books and magazines)
    5. Other _____

13. Have you previously sought professional psychological help from a counselor?
    1. No
    2. Yes

14. If you answered, "yes" to question #13, in your opinion, in which type of community did you receive treatment?
    1. Urban
    2. Rural

15. If you have previously sought professional psychological help, how would you rate your most recent experience?
    1. Very Poor
    2. Poor
    3. Good
    4. Very Good

16. If you have previously sought professional psychological help, do you feel that your therapist understood you and/or your problem?
    1. Not at all
    2. Somewhat
    3. Yes, very well

Comments:

_____

APPENDIX D. TABLES

Table 1

Summary of Hierarchical Regression Analysis for Parent Attitudes Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Parent Community Size	.07	.19	.35	.72	.72
Student Community Size	.16	.20	.82	.42	.42
Parent Sex	-.09	.16	-.56	.58	.58
Student Sex	-.57	.17	-3.44	.00	.00
Step 2					
Parent Community Size	.06	.19	.30	.03	.76
Student Community Size	.10	.20	.52	.05	.60
Parent Sex	.02	.16	.13	.01	.90
Student Sex	-.57	.16	-3.53	-.24	.00
Parent Attitude	.22	.07	3.192	.23	.00
Step 3					
Parent Community Size	.05	.19	.24	02	.81
Student Community Size	.13	.20	.65	.06	.52
Parent Sex	.04	.18	.23	.02	.82
Student Sex	-.56	.20	-2.70	-.03	.01
Parent Attitude	.17	.09	1.90	.17	.06
Student Sex x Parent Attitude	.27	.17	1.57	.13	.12
Parent Sex x Parent Attitude	-.01	.16	-.06	-.01	.95
Student Sex x Parent Sex	-.02	.36	-.06	-.01	.95
Step 4					
Parent Community Size	.05	.19	.24	.02	.81
Student Community Size	.13	.20	.63	.06	.53
Parent Sex	.04	.18	.21	.02	.83
Student Sex	-.55	.21	-2.66	-.23	.01
Parent Attitude	.17	.09	1.90	.17	.06
Student Sex x Parent Attitude	.24	.21	1.18	.12	.24
Parent Sex x Parent Attitude	-.03	.18	-.17	-.02	.87
Student Sex x Parent Sex	.00	.37	.00	.00	.10
Student Sex x Parent Sex x Parent Attitude	.09	.38	.24	.03	.81

Note. $R^2 = .07$, $F(4, 189) = 3.54$, $p = .01$ for Step 1; $\Delta R^2 = .05$, $F(1, 188) = 10.18$, $p = .00$ for Step 2; $\Delta R^2 = .01$, $F(3, 185) = .92$, $p = .43$ for Step 3; $\Delta R^2 = .000$, $F(1, 184) = .06$, $p = .81$ for Step 4 ($p < .05$).

Table 2

Summary of Hierarchical Regression Analysis for Parent Attitudes and Attachment Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Parent Community Size	.08	.19	.41	.04	.68
Student Community Size	.17	.20	.83	.08	.41
Parent Sex	-.07	.16	-.46	-.03	.65
Student Sex	-.56	.17	-3.35	-.24	.00
Step 2					
Parent Community Size	.03	.19	.14	.01	.89
Student Community Size	.11	.20	.58	.05	.57
Parent Sex	.08	.16	.51	.04	.61
Student Sex	-.47	.17	-2.77	-.20	.01
Parent Attitude	.20	.07	2.63	.20	.01
Attachment to Mother	.14	.09	1.59	.14	.11
Attachment to Father	.02	.08	.30	.02	.76
Step 3					
Parent Community Size	.02	.19	.10	.01	.92
Student Community Size	.13	.21	.64	.06	.53
Parent Sex	.08	.13	.47	.04	.64
Student Sex	-.46	.17	-2.67	-.20	.01
Parent Attitude	.19	.08	2.40	.19	.02
Attachment to Mother	.15	.09	1.61	.14	.12
Attachment to Father	.01	.09	.16	.01	.87
Parent Attitude x Attachment to Mother x Attachment to Father	.02	.06	.32	.03	.75

Note. $R^2 = .07$, $F(4, 185) = 3.41$, $p = .01$ for Step 1; $\Delta R^2 = .07$, $F(3, 182) = 4.77$, $p = .00$ for Step 2; $\Delta R^2 = .00$, $F(1, 181) = .10$, $p = .75$ for Step 3 (ps < .05).

Table 3

Summary of Hierarchical Regression Analysis for Attachment (Composite Variable) Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Parent Community Size	.17	.15	1.17	.08	.24
Parent Sex	-.07	.15	-.46	-.03	.65
Student Sex	-.58	.17	-3.50	-.25	.00
Step 2					
Parent Community Size	.09	.14	.64	.05	.52
Parent Sex	.04	.15	.28	.02	.78
Student Sex	-.48	.17	-2.90	-.21	.00
Parent Attitude	.21	.07	3.07	.21	.00
Attachment Composite	.17	.09	2.02	.14	.05
Step 3					
Parent Community Size	.09	.14	.64	.05	.52
Parent Sex	.04	.15	.28	.02	.78
Student Sex	-.48	.17	-2.88	-.21	.00
Parent Attitude	.21	.07	3.02	.21	.00
Attachment Composite	.17	.09	1.90	.14	.06
Parent Attitude x Attachment Composite	-.01	.09	-.12	-.01	.91

Note. $R^2 = .14$, $F(3, 190) = 4.51$, $p = .00$ for Step 1; $\Delta R^2 = .07$, $F(2, 188) = 7.45$, $p = .00$ for Step 2; $\Delta R^2 = .00$, $F(1, 187) = .01$, $p = .91$ for Step 3 ($p < .05$)

Table 4

Summary of Hierarchical Regression Analysis for Attachment (Correcting for Collinearity, Father-Only) Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Parent Community Size	.08	.19	.41	.04	.68
Student Community Size	.17	.20	.83	.08	.41
Parent Sex	-.07	.16	-.46	-.03	.65
Student Sex	-.56	.17	-3.35	-.24	.00
Step 2					
Parent Community Size	.06	.19	.31	.03	.76
Student Community Size	.12	.20	.54	.05	.59
Parent Sex	.02	.16	.13	.01	.90
Student Sex	-.51	.17	-3.08	-.22	.00
Parent Attitude	.23	.07	3.29	.24	.00
Attachment to Father	.08	.07	1.15	.08	.25
Step 3					
Parent Community Size	.06	.19	.30	.03	.77
Student Community Size	.11	.20	.54	.05	.59
Parent Sex	.01	.16	.06	.00	.95
Student Sex	-.49	.17	-2.94	-.21	.00
Parent Attitude	.22	.07	3.03	.22	.00
Attachment to Father	.08	.07	1.08	.08	.28
Parent Attitude x Attachment to Father	-.07	.07	-1.11	-.08	.27

Note. $R^2 = .07$, $F(4, 185) = 3.41$, $p = .01$ for Step 1; $\Delta R^2 = .06$, $F(2, 183) = 5.84$, $p = .00$ for Step 2; $\Delta R^2 = .01$, $F(1, 182) = 1.22$, $p = .27$ for Step 3 ($p < .05$).

Table 5

Summary of Hierarchical Regression Analysis for Attachment (Correcting for Collinearity, Mother-Only) Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Parent Community Size	.07	.19	.41	.03	.72
Student Community Size	.17	.20	.83	.08	.41
Parent Sex	-.09	.16	-.46	-.03	.58
Student Sex	-.57	.17	-3.35	-.24	.00
Step 2					
Parent Community Size	.01	.19	.06	.01	.95
Student Community Size	.11	.20	.58	.05	.56
Parent Sex	.08	.16	.51	.04	.61
Student Sex	-.48	.17	-2.89	-.20	.00
Parent Attitude	.18	.07	2.57	.19	.01
Attachment to Mother	.16	.08	2.14	.16	.03
Step 3					
Parent Community Size	.02	.19	.10	.01	.92
Student Community Size	.09	.20	.48	.04	.63
Parent Sex	.08	.16	.51	.04	.61
Student Sex	-.48	.17	-2.86	-.20	.00
Parent Attitude	.18	.07	2.55	.19	.01
Attachment to Mother	.19	.08	2.28	.18	.02
Parent Attitude x Attachment to Mother	.06	.07	.81	.06	.42

Note. $R^2 = .07$, $F(4, 189) = 3.54$, $p = .01$ for Step 1; $\Delta R^2 = .07$, $F(2, 187) = 7.47$, $p = .00$ for Step 2; $\Delta R^2 = .00$, $F(1, 186) = .67$, $p = .42$ for Step 3 ($p < .05$).

Table 6

Summary of Hierarchical Regression Analysis for Community Size (Students-Only) Predicting Adult Children's Attitudes (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Student Community Size	.19	.15	1.27	.09	.21
Student Sex	-.58	.17	-3.52	-.25	.00
Step 2					
Student Sex	-.43	.20	-2.16	-.18	.03
Student Community Size	.29	.17	1.73	.14	.09
Student Sex x Student Community Size	-.45	.35	-1.27	-.12	.20

Note. $R^2 = .07$, $F(2, 192) = 7.01$, $p = .00$ for Step 1; $\Delta R^2 = .01$, $F(1, 191) = 1.62$, $p = .20$ for Step 2 ($p < .05$).

Table 7

Summary of Hierarchical Regression Analysis for Community Size (Students-Only) Predicting Adult Children's Intent (N = 195)

Variable	B	SE B	t	ß	*p*
Step 1					
Student Sex	-.50	.17	-2.97	-.21	.00
Student Community Size	.02	.16	.13	.01	.90
Step 2					
Student Sex	-.30	.20	-1.44	-.12	.15
Student Community Size	.17	.18	.96	.08	.34
Student Sex x Student Community Size	-.64	.36	-1.78	-.17	.09

Note. $R^2 = .05$, $F(3, 190) = 2.98$, $p = .03$ for Step 1; $\Delta R^2 = .02$, $F(1, 189) = 3.17$, $p = .09$ for Step 2 ($p < .05$).

Table 8

Summary of Hierarchical Regression Analysis for Mother and Father Data Predicting Adult Children's Attitudes (N = 22)

Variable	B	SE B	t	ß	*p*
Step 1					
Student Sex	-.64	.47	-1.37	-.29	.19
Step 2					
Student Sex	-.37	.47	-.80	-.17	.44
Mother Attitude	.20	.21	.96	.20	.35
Father Attitude	.39	.22	1.75	.39	.10
Step 3					
Student Sex	-.50	.47	-1.07	-.23	.30
Mother Attitude	.18	.21	.90	.18	.38
Father Attitude	.24	.24	1.04	.24	.32
Attachment to Mother	.39	.26	1.50	.39	.15
Attachment to Father	-.11	.24	-.45	-.11	.66
Step 4					
Student Sex	-.66	.49	-1.35	-.30	.20
Mother Attitude	.35	.26	1.37	.35	.19
Father Attitude	.07	.26	.27	.07	.79
Attachment to Mother	.66	.31	2.17	.66	.05
Attachment to Father	-.20	.27	-.74	-.20	.47
Mother Attitude x Attachment to Mother	-.53	.33	-1.60	-.41	.13
Father Attitude x Attachment to Father	-.05	.24	-.20	-.05	.84

Note. $R^2 = .09$, $F(1, 20) = 1.87$, $p = .19$ for Step 1; $\Delta R^2 = .22$, $F(2, 18) = 2.78$, $p = .09$ for Step 2; $\Delta R^2 = .10$, $F(2, 16) = 1.27$, $p = .31$ for Step 3; $\Delta R^2 = .10$, $F(2, 14) = 1.46$, $p = .27$ for Step 4 ($p < .05$).

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